TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MEMORIAL COMPOUNDING RX

Respondent Name
State Farm Fire & Casualty Co

MFDR Tracking Number
M4-18-1128-01

Carrier's Austin Representative
Box 1

MFDR Date Received
December 18, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Memorial did not receive any correspondence as per rule so we submitted a Request for Reconsideration…As of today, we still haven't received any correspondences."

Amount in Dispute: $284.92

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based upon the Carrier's review of the information provided, as well as their records, it appears that payment was made in full as of December 14, 2017. (See Exhibit A). Further, the undersigned attorney for the Carrier contacted the Requestor's representative [name] via email (See attached Exhibit B) on January 4, 2018 to advise that payment had already been made on the charges at issue…No response has been received."

Response Submitted by: Smith & Carr PC

SUMMARY OF FINDINGS

Date of Service	Disputed Services	Amount In Dispute	Amount Due
April 21, 2017	Prescription Medication	$284.92	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes
2. 28 Texas Administrative Code §134.503 sets out the reimbursement for compound medications
3. Payment Issued November 25, 2017 and Paid to Memorial on December 14, 2017
   - Payment in the amount of $284.92 check number 125017344K, no reduction,

Findings

The Division makes the following conclusions based upon the information and documentation presented to the Division to date. Even though all the evidence was not discussed, it was considered.

1. Did the carrier make a payment for the disputed services?

Memorial Compounding Rx (Memorial) asserts that it billed the carrier for the service in dispute, but did not receive any response from the carrier.

Review of the documentation provided finds that the carrier issued a payment in the amount of $284.92 to Memorial Compounding Pharmacy on November 25, 2017 under check numbered 125017344K, and that the status of that check was "paid" as of December 14, 2017.

Memorial was notified by the Carrier and by the Division's medical fee dispute resolution program of the payment, however Memorial has not taken the opportunity to refute the carrier's position or respond to the Division's with additional information.

For that reasons, the Division moves to resolve this dispute with the information available and concludes that no additional reimbursement can be recommended.

Conclusion

The Division concludes that Memorial has already been paid for the $284.92 in dispute. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, and pursuant to Texas Labor Code Section 413.031, the division has determined that the requestor is not entitled to additional reimbursement for the services in dispute.

Authorized Signature

		January 31, 2018
Signature	Medical Fee Dispute Resolution Director	Date

RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.